

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 1 2 8 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Wade W. Barker</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 16, 1981</b>		2b. HOUR <b>4:45P</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MAR. 16, 1913</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil Co. MD.</b>		
10. CITY OR TOWN OF DEATH <b>PERRYVILLE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PERRY POINT V.A. HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MASON</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. CITY OR TOWN <b>HARFORD</b>	13c. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13d. STREET ADDRESS <b>1502 GLENVILLE RD.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ROSCOE M. BARKER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LUCKY - SPENCER</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>YES WW II</b>		16b. SOCIAL SECURITY NO. <b>216 09 8616</b>		17. INFORMANT ADDRESS <b>VAMC, Perry Point, Maryland</b>	

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory failure</b> <b>4140</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerotic heart disease</b> <b>Congestive Heart Failure - Azotemia Anemia</b> (c) <b>Rheumatoid arthritis gout.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12-18-80</b> 19 to <b>8-16-</b> 19 <b>81</b> , that <b>xx</b> (we) last saw the deceased alive on <b>8-16-</b> 19 <b>81</b> , and that in <b>xx</b> (our) opinion death occurred on the date and hour and from the causes stated above <b>xx</b> (we) (did <b>xx</b> (not) view the body after death.			
22b. SIGNATURE <b>R. Tripathi</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>8-16-81</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RAJENDRA P. TRIPATHI, M.D.</b>		22e. ADDRESS <b>VAMC, Perry Point, Maryland</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>AUG 18, 1981</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SIBEL AIR MEMORIAL GARDENS</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>BELAIR HARFORD, MD.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>P. Madison Mitchell, Funeral Director</b> <b>123 S. Washington St., Havre de Grace, Md.</b>		25. DATE REC'D. BY REGISTRAR <b>AUG 18 1981</b> REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>	

BP

(M)

Wade W. Martin

August 18, 1981

4:35

Wade W. Martin, Party Point, Maryland

Cardiology history failure  
Atherosclerosis heart disease  
Compressive heart failure - Atherosclerosis  
Atherosclerosis atherosclerosis

8-18-81

12-18-81

8-18-81

8-18-81

Wade W. Martin, Party Point, Maryland

Wade W. Martin, Party Point, Maryland

AUG 18 1981

W. Martin, Party Point, Maryland

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 2 8 8	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RUSSELL EMMETT CAMPBELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 25, 1981</b>		2b. HOUR <b>9:25am</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MAR. 30, 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>CECIL</b> MD.		
10. CITY OR TOWN OF DEATH <b>Perry Point</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DRY CLEANER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CLOTHES</b>
13a. STATE <b>MD</b>		13b. COUNTY <b>HARFORD</b>	13c. CITY OR TOWN <b>HAVREDEGRAPE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>324 S. WASHINGTON ST.</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>RUSSELL E. CAMPBELL SR.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY LAWRENCE</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES.</b>		16b. SOCIAL SECURITY NO. <b>218-18-5160</b>		17. INFORMANT ADDRESS <b>Mrs. MOLLIE L. CAMPBELL, SAME</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> <b>4149</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Generalized arteriosclerosis, right cerebral embolus</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 17</b> , 19 <b>81</b> to <b>August 25</b> , 19 <b>81</b> xxxxxxxx and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Klaus H. Huebner</b> DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>8-25-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. H. HUEBNER, M.D.</b>		22e. ADDRESS <b>VAMC, Perry Point, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>AUG 27, 81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ANGEL HILL CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>HAVREDEGRAPE HARFORD MD</b>
24. FUNERAL DIRECTOR <b>R. Madison Mitchell Funeral Home, Havre de Grape, Md.</b>			25. RECEIVED BY BALTIMORE REGISTRAR'S SIGNATURE <b>AUG 31 1981</b>		

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K. H. HUBNER, M.D.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 2 1 2 8 9			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN J. CARROLL				2a. DATE OF DEATH MONTH DAY YEAR AUGUST 15, 1981			
3 SEX Male				2b. HOUR a. m.			
4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR JULY 5, 1896		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? USA		9 BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10 CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b KIND OF BUSINESS OR INDUSTRY Elkton Supply Co.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b COUNTY Cecil		13c CITY OR TOWN Elkton		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST James Arthur Carroll				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ann Monahan			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO 213-05-6165		17 INFORMANT ADDRESS William H. Carroll, Elkton, Md. 21921			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE			
22a I certify that (If this hospital) attended the deceased from 19 <u>78</u> , to <u>present</u> , 19 <u>81</u> , that (I) <u>have</u> last saw the deceased alive on <u>June 15, 1981</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>have</u> (did) not view the body after death.							
22b SIGNATURE <u>Robert L. Gray</u> M.D.				DEGREE M.D.		22c DATE SIGNED 8/17/81	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Robert L. Gray, M.D.				22e ADDRESS 719 Bridge Street, Elkton, Md. 21921			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 8/17/81		23c NAME OF CEMETERY OR CREMATORY Elkton Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Elkton Maryland	
24 FUNERAL DIRECTOR NAME <u>Joseph E. Hicks</u> ADDRESS HICKS HOME for FUNERALS, ELKTON, MD.				25a DATE REC'D. BY REGISTRAR AUG 24 1981		25b REGISTRAR'S SIGNATURE <u>James J. [Signature]</u>	



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	2	1	2	9	0		
FOR 1 - STATE REGISTRAR										REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) <u>Andrew</u> <u>Richard</u> <u>Conrad, Sr.</u>										2a. DATE OF DEATH MONTH DAY YEAR <u>August 28, 1981</u>				2b. HOUR <u>8:10 P</u> <sup>M</sup>				
3 SEX <u>Male</u>			4 RACE <u>White</u>			5. DATE OF BIRTH MONTH DAY YEAR <u>May 2, 1923</u>			6. AGE (IN YEARS LAST BIRTHDAY) <u>58</u> YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Baltimore, Md.</u>			7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>Cecil</u> MD.									
10. CITY OR TOWN OF DEATH <u>Elkton</u>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Union Hospital</u>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Builder</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Plasticoid</u>						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
13a. STATE <u>Md.</u>			13b. COUNTY <u>Cecil</u>			13c. CITY OR TOWN <u>Elkton</u>			13e. STREET ADDRESS <u>138 Friendship Road</u>									
14. FATHER'S NAME FIRST MIDDLE LAST <u>no info.</u>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Cecelia Conrad</u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>			16b. SOCIAL SECURITY NO. <u>219-10-8040</u>			17. INFORMANT ADDRESS <u>Edith E. Conrad 138 Friendship Rd., Md. Elkton</u>												
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: <u>4100</u> IMMEDIATE CAUSE (a) <u>Auto Myocard Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>family ill Arteriosclerotic Vascular disease</u> (c) <u>Due to, or as a consequence of</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																		
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from <u>10/2</u> 19 <u>74</u> to <u>8/29</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>8/29</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <u>Jui-Chih Hsu MD</u>										DEGREE <u>M</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>8/31/81</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jui-Chih Hsu, M.D.</u>										22e. ADDRESS <u>223 W. main St, Elkton, Md. 21921</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>Sept. 1, 1981</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>			23d. LOCATION CITY OR TOWN COUNTY STATE <u>Elkton</u>									
24. FUNERAL DIRECTOR NAME <u>SEE FUNERAL HOME</u> ADDRESS <u>P.A. Elkton, Md.</u>																		

MEDICAL CERTIFICATION





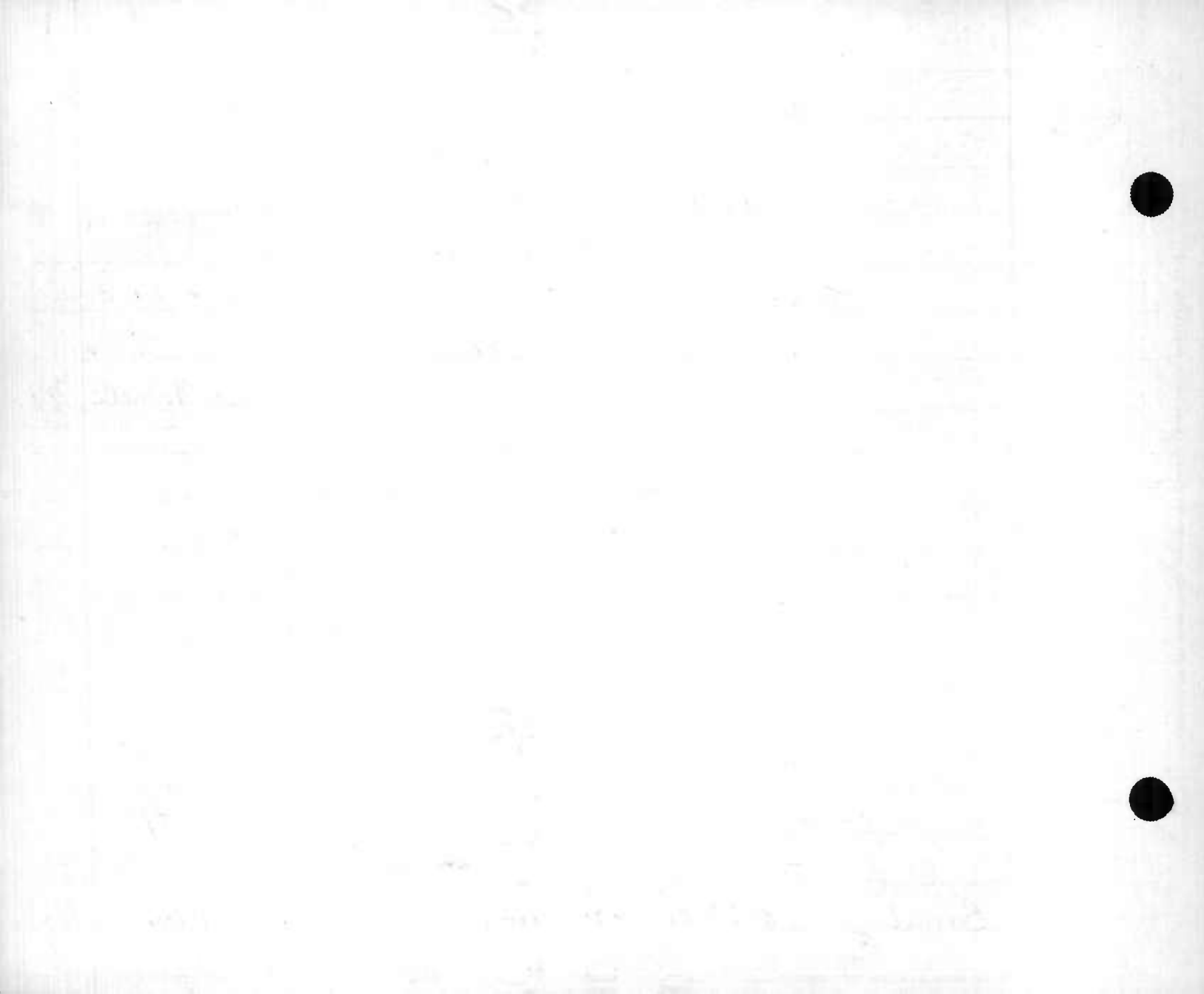
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO.				8121291				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Alberta R. Crane</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>8-23-81</i>			2b. HOUR <i>9:35 AM</i>		
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>9-12-87</i>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <i>93</i> YRS		IF UNDER 1 YEAR IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Alabama</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i> MD.				
10. CITY OR TOWN OF DEATH <i>Elkton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Laurelwood Nursing Center</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <i>Md.</i>					13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>St. Michael's</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>George J. Jung</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Jewel</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>26K-78-0563</i>		17. INFORMANT ADDRESS <i>Mrs. Wm. Crane St. Michael's, Md.</i>						
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> 4140 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Aspiration - Malnutrition</i> (c) <i>Gen - Debilitated condition</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>7/4/81</i> 19____, to _____ 19____, that (I) (we) lost saw the deceased alive on <i>8/5/81</i> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Jayantilal K. Patel</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>8/24/81</i>		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. J. Patel</i>		22a. ADDRESS <i>123 SINGERLY AVE Elkton, Md. 21821</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>8-27-81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fairview Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Westfield Union N.Y.</i>				
24. FUNERAL DIRECTOR NAME <i>Newnam Funeral Home</i>				ADDRESS <i>Easton, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>AUG 31 1981</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

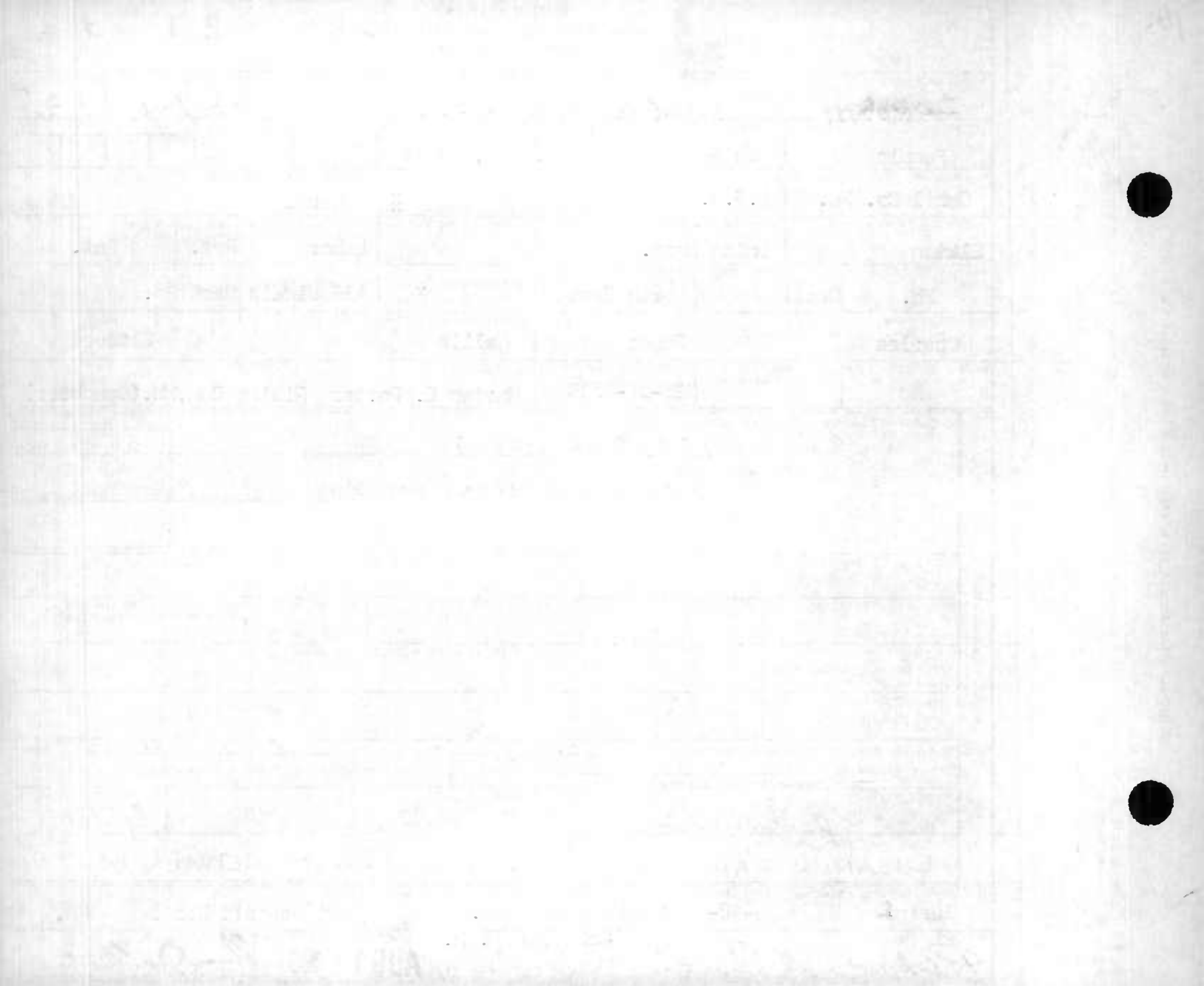
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM: 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 2 1 2 9 2  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		8-7-81		7:36 P	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		Nov. 9, 1911		69 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Cecil Co. Md.		U.S.A.				Cecil MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Elkton		Union Hosp.		Labor Ret.		Ret.	
13a. STATE		13b. COUNTY		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS	
Md.		Cecil		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		430 Bideik Neck Rd.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO	
Charles		Nellie		No		220-34-7319	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Marian E. Potter		Rising Sun, Md. (Daughter)		PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ISCHEMIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		30 min.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
EHSANUR RAHMAN		MD				8/9/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
		314, E. MAIN ST., NEWARK, DE 19711					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		8-10-1981		Hopewell Cem.		Port Deposit Cecil Md.	
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Richard L. Goodie		Rising Sun		McMullen F. H.		AUG 11 1981	
						REGISTRAR'S SIGNATURE	
						Name Jan Norton	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
8 1 2 1 2 9 3									
FOR 1. STATE REGISTRAR									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Spry H. Cummerford</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>8 19 81</b>		7b. HOUR <b>6:15p M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 2, 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil MD</b>			
10. CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital of Cecil Co,</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Painter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>House Ptr.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Md.</b>		13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>Elkton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>116 Park Circle</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Cummerford</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Kathleen Dixon</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No.</b>				16b. SOCIAL SECURITY NO. <b>217-09-5549</b>		17. INFORMANT ADDRESS <b>Elkton, Md. Jennie Carroll, 116 Park Circle,</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, Lung</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a. <b>Acute Myocardial Infarction, COPD, and ASHD</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 19 <b>81</b> , to <b>Aug 18</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>Aug 19</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Wallace Obenshain M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>21 Aug 81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Wallace Obenshain, M.D.</b>				22e. ADDRESS <b>Cecilton, Md. 21913</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/23/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Massey Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Massey Kent Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Edward Fellows &amp; Son, Millington, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>21651</b>		25b. REGISTRAR'S SIGNATURE <b>AUG 26 1981</b>		<b>Frances J. Nathan</b>	

BP \_\_\_\_\_

THE END OF THE WORLD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
I. DECEASED NAME (TYPE OR PRINT) <b>JOHN J. Demniansky (DEMNAINYK), Jr.</b>					2a. DATE OF DEATH <b>August 6, 1981</b>		2b. HOUR <b>6:00A</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>April 7, 1922</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Phila. Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b>			
10. CITY OR TOWN OF DEATH <b>Perry Point</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center, Perry Point, MD</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Tool&amp;Die</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Machinist</b>	
13a. STATE <b>Penna.</b>		13b. COUNTY <b>Philadelphia</b>		13c. CITY OR TOWN <b>Philadelphia</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS <b>821 N. Franklin St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John J. Demniansky, Sr.</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Swystum</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW 11</b>		17. INFORMANT (Sister) <b>Stephanie Wochok</b>		ADDRESS <b>Same as #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest</b> <b>4149</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Hypertension</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Apr 10</b> , 19 <b>81</b> to <b>Aug 6</b> , 19 <b>81</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Aug 6</b> , 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> view the body after death.									
22b. SIGNATURE <b>Joseph J. Kim</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>8/6/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSEPH J. KIM, M.D.</b>				22e. ADDRESS <b>VAMC Perry Point, Md. 21902</b>					
23a. BURIAL, CREMATION, REMOVAL (SMBRV) <b>Burial</b>		23b. DATE <b>8/11/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Abington Montgomery Pa.</b>			
24. FUNERAL DIRECTOR <b>E. Barnes</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 10 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Flaming Funeral Service Benson, Md.</b>			

BP

ADJ. GEN. 1000

77 Medical Center, Terry Point, MD

195-02-172

Carole's primary cancer  
(formerly active disease)

Hypertension

7700 Terry Point, MD 21005

JOSEPH J. J. J.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17 20M 1/73  
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21295	
1. DECEASED NAME (TYPE OR PRINT) <b>Thomas Kevin Epp</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>8</b> DAY <b>15</b> YEAR <b>1981</b>	
3. SEX <b>M</b>	4. RACE <b>C</b>	5. DATE OF BIRTH MONTH <b>10</b> DAY <b>17</b> YEAR <b>59</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>21</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.	IF UNDER 24 HRS. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.	2c. DATE PRONOUNCED DEAD <b>8/15/81</b>		2d. HOUR <b>6:55 PM</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil Co. MD.</b>				
10. CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>none</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>PA.</b> 13b. CITY OR TOWN <b>Chester</b> 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13d. STREET ADDRESS <b>743 E. Chestnut St.</b>											
14. FATHER'S NAME FIRST <b>Raymond</b> MIDDLE <b>L.</b> LAST <b>Smith</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Lillian</b> MIDDLE <b>M.</b> LAST <b>Christman</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>190-50-0020</b>		17. INFORMANT ADDRESS <b>foster parents 743 Chestnut St. Coatesville, Pa.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Head Injury</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Auto Accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>8121</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>6:58 PM 8/15/81</b>				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6:58 PM 8/15/81</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Mr Epp on back of car - hit by a truck</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Road</b>				21f. LOCATION STREET <b>US 222 @ Md 275</b> CITY OR TOWN <b>Cecil</b> COUNTY <b>MD.</b> STATE <b>MD.</b>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Henry Farkas</b>				TITLE (SPECIFY) <b>Deputy</b> M.D. MEDICAL EXAMINER				DATE SIGNED <b>8/15/81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Henry Farkas MD</b>				ADDRESS <b>Union Hosp. of Cecil County Elkton</b>							
23a. BURIAL, CREMATION, REMOVAL (SPEC) <b>Burial</b>		23b. DATE <b>8-19-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>				23d. LOCATION CITY OR TOWN <b>Coatesville</b> COUNTY <b>Chester</b> STATE <b>Pa.</b>			
24. FUNERAL DIRECTOR'S NAME <b>GEE FUNERAL Home</b> ADDRESS <b>259 E MAIN ST ELKTON MD</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 20 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

722

Handwritten notes and diagrams on lined paper, including a circular diagram with internal markings and various illegible text fragments.

Printed text at the bottom of the page, including a date and other administrative markings.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

DHMH - 16 50M 1/81  
(VRA 15, 4)

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO. 8 1 2 1 2 9 6	
1. DECEASED NAME (TYPE OR PRINT) <b>RALPH E. FOX</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>August 11, 1981</b>		2b. HOUR <b>12:47pm</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Mar. 7, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS. MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD	
10. CITY OR TOWN OF DEATH <b>Perry Point</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Army</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Military</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Cecil</b>	13c. CITY OR TOWN <b>North East</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Martin Fox</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Hartman</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII &amp; Korea 176-32-1824</b>		17. INFORMANT <b>P.O. Box 141</b> <b>Regina G. Fox North East, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hepato-Renal Syndrome</b> <b>5712</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cirrhosis of the Liver</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Chronic Alcoholism</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 17</b> , 19 <b>81</b> , to <b>August 11</b> , 19 <b>81</b> . <del>now the deceased died on</del> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE <b>K. H. Huebner</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. H. HUEBNER, M.D.</b>		22e. ADDRESS <b>VAMC, Perry Point, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Aug. 15-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>North East Meth.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>North East Cecil Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 14 1981</b>			
24. FUNERAL DIRECTOR NAME <b>Crouch Funeral Home, North East, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Nelson</b>			

MEDICAL CERTIFICATION

19

Group Funeral Home, North East, Md.

K. H. FERNER, D.D.

WACO, Perry Point, Md.

July 17

65

August 15

61

Chronic Alcoholism

Cirrhosis of the Liver

Hepato-Renal Syndrome

176-32-112A

VA Medical Center

Perry Point

FOX

August 11, 1961

12:47P

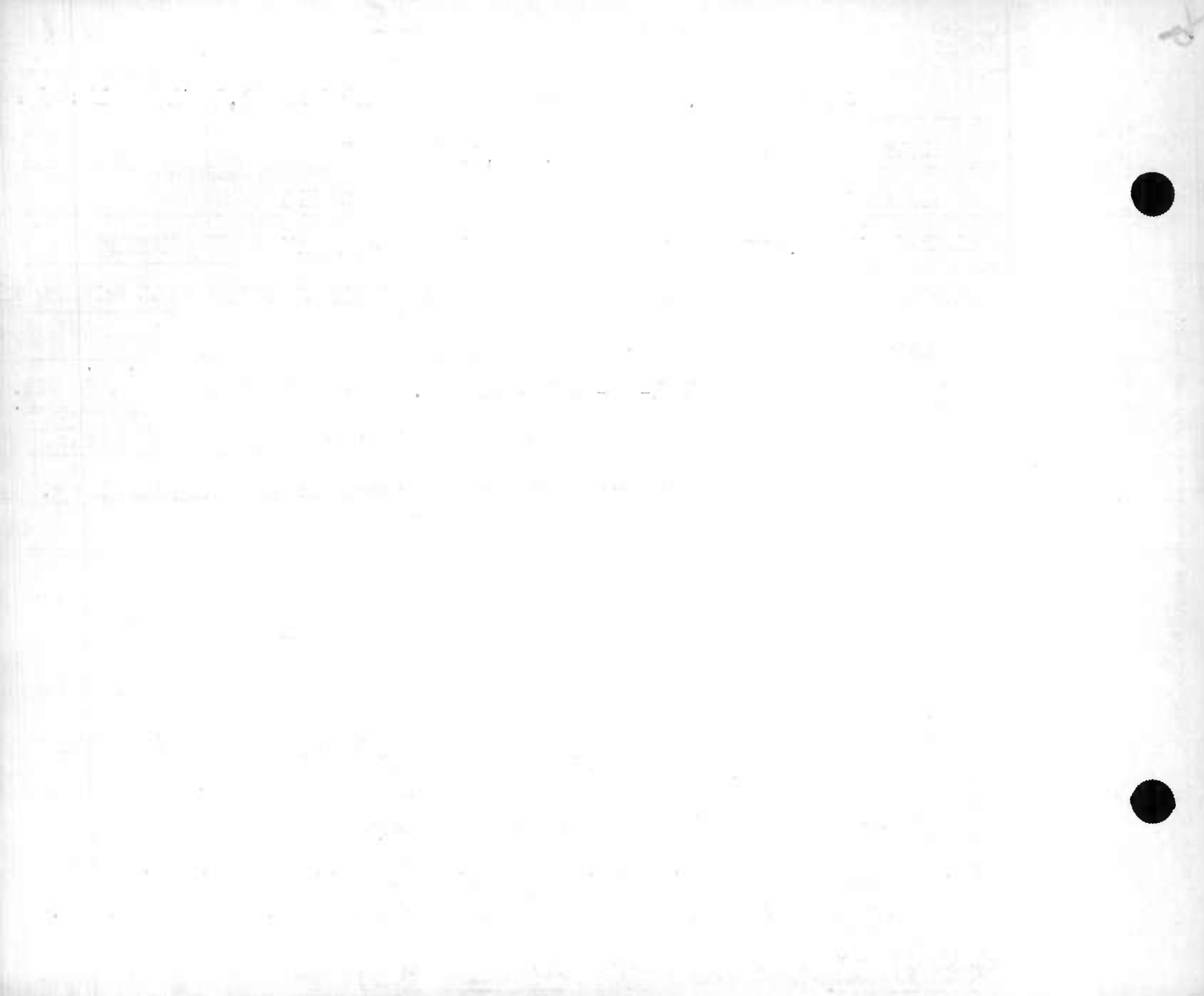
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 2 1 2 9 7	
FOR 1- STATE REGISTRAR			REG. NO.								
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST JAMES B. FRAZER			2a DATE OF DEATH MONTH DAY YEAR AUGUST 21, 1981			2b HOUR 11:45 P		
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR NOV. 23, 1893		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b CITIZEN OF WHAT COUNTRY? US			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH CECIL MD.		
10 CITY OR TOWN OF DEATH ELKTON			11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DEVINE HAVEN NURSING HOME			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FOREMAN			12b KIND OF BUSINESS OR INDUSTRY FIBRE		
13a STATE MARYLAND			13b COUNTY CECIL		13c CITY OR TOWN ELKTON		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 432B JACKSON HALL SCHOOL RD.		
14 FATHER'S NAME FIRST MIDDLE LAST SAMUEL FRAZER			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATE GARY			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b SOCIAL SECURITY NO. 221-07-965		
17 INFORMANT JAMES H. FRAZER			ADDRESS ELKTON, MD. 440 JACKSON HALL SCH. RD.			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure 4049 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic cardiovascular (c) renal disease Over 1 yr.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22 I certify that (I) (the hospital) attended the deceased from Oct. 31, 1980, to Aug. 21, 1981, that (I) (we) lost saw the deceased alive on Aug. 21, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22a SIGNATURE S. Ralph Andrews, Jr.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED 8/22/81		
22d PHYSICIAN'S NAME (TYPE OR PRINT) S. Ralph Andrews, Jr., M.D.			22e ADDRESS 233 E. Main St., Elkton, Md. 21921								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE 8/25/81		23c NAME OF CEMETERY OR CREMATORY HEAD OF CHRISTIANA			23d LOCATION NEWARK, NEW CASTLE, DEL.			
24 FUNERAL DIRECTOR NAME Robert T. Jones						ADDRESS Newark, Del.		25a DATE REC'D. BY REGISTRAR AUG 22 1981		25b REGISTRAR'S SIGNATURE James J. Jones	

BP

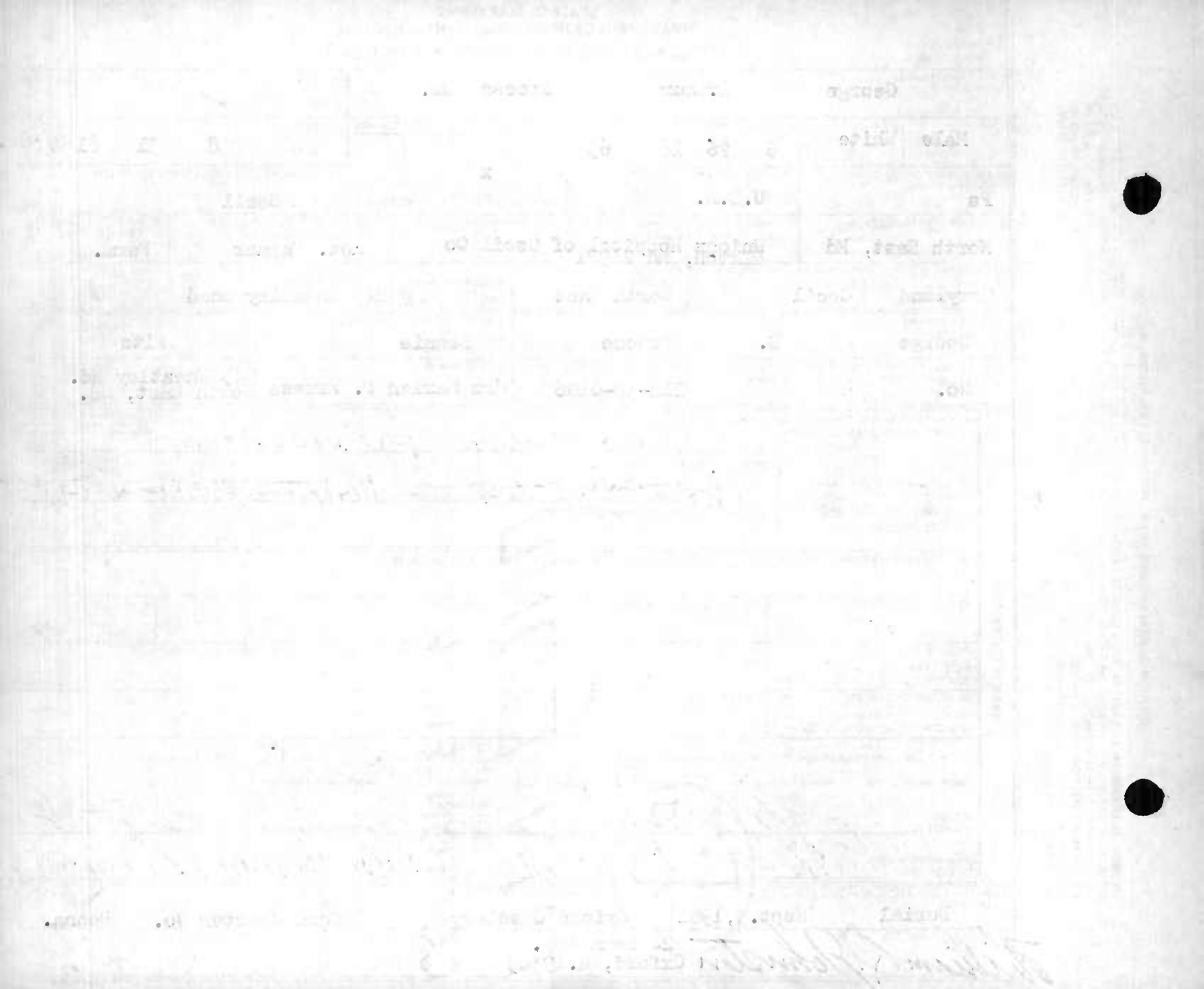


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21298		
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR
1. DECEASED NAME (TYPE OR PRINT) <b>George Arthur Freese Sr.</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 19		2b. HOUR <input type="checkbox"/> M
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>6</b> DAY <b>26</b> YEAR <b>18</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD MONTH <b>8</b> DAY <b>31</b> YEAR <b>81</b>		2d. HOUR <b>8/36P.</b> M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.						
10. CITY OR TOWN OF DEATH <b>North East, Md</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital of Cecil Co, Eickon, Md 21921</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Farm.</b>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>North East</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>845 Wheatley Road</b>				
14. FATHER'S NAME FIRST <b>George</b> MIDDLE <b>D.</b> LAST <b>Freese</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Lennie</b> MIDDLE <b>Fitz</b> LAST <b>Fitz</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No.</b> (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. <b>212-38-0106</b>		17. INFORMANT ADDRESS <b>845 Wheatley Rd. Mrs Marian P. Freese North East, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4140 VENTRICULAR FIBRILLATION</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>7/5</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>AVANT B. SINGH</b>				TITLE (SPECIFY) <b>DEPUTY</b> M.D. <b>DEPUTY</b> MEDICAL EXAMINER				DATE SIGNED <b>8/31/81</b>				
EXAMINER'S NAME (TYPE OR PRINT) <b>AVANT B. SINGH</b>				ADDRESS <b>UNION HOSPITAL, Eickon, Md 21921</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Sept. 3, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oxford Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Oxford</b> COUNTY <b>Chester Co.</b> STATE <b>Penna.</b>				
24. FUNERAL DIRECTOR <b>William G. Johnston</b>				224 Penn Ave. Oxford, Pa. 19363				25a. DATE REC'D. BY REGISTRAR <b>SEP 8 1981</b>		25b. REGISTRAR'S SIGNATURE <b>James J. ...</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR									
CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <u>MARION M Given</u>					2a. DATE OF DEATH MONTH <u>8</u> DAY <u>6</u> YEAR <u>1981</u>		2b. HOUR <u>530A</u>		
3. SEX <u>F</u>		4. RACE <u>W</u>		5. DATE OF BIRTH MONTH <u>9</u> DAY <u>11</u> YEAR <u>1989</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>91</u>		7. UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>CECIL</u> MD.			
10. CITY OR TOWN OF DEATH <u>ELATON</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>W H HION</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>HOUSEWIFE</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
13a. STATE <u>MD</u>		13b. COUNTY <u>CECIL</u>		13c. CITY OR TOWN <u>CHESAPEAKE</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>RD 1</u>	
14. FATHER'S NAME FIRST <u>ADAM</u> MIDDLE <u></u> LAST <u>MEISEL</u>					15. MOTHER'S MAIDEN NAME FIRST <u>MARGARET</u> MIDDLE <u></u> LAST <u>BUTCHER</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>219-P-8705</u>		17. INFORMANT <u>EMILY L. GIVEN</u>		ADDRESS <u>CHESAPEAKE CITY MD</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST.</u> <u>4360</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>S/p Cerebro-Vascular Accident</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (his hospital) attended the deceased from <u>8/4</u> , 19 <u>81</u> to <u>8/6</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>8/5</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>JoAnn Rosenfeld, MD.</u>		DEGREE <u>MD.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8/10/81</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JoAnn Rosenfeld, MD.</u>		22e. ADDRESS <u>Cecil ton, MD</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>8-9-81</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BETHEL</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>CHESAPEAKE CITY CECIL MD</u>			
24. FUNERAL DIRECTOR NAME <u>RT. ROAD FUNERAL HOME</u> CITY <u>MD</u>									

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Handwritten notes on lined paper, including a large circular stamp on the left side and several lines of text.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 2 1 3 0 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY E. LAST Guerrieri			2a. DATE OF DEATH MONTH DAY YEAR 8-15-81		2b. HOUR 10:50 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 06 10 02		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil County		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Delaware		13b. COUNTY New Castle		13c. CITY OR TOWN Newark		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph - Kady		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 059-03-3647		17. INFORMANT ADDRESS Mr. S.A. Guerrieri, Newark, Del. 19711					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CVA. 4360 DUE TO, OR AS A CONSEQUENCE OF (b) ASD, Hypertension. DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/5, 1979, to 8/15, 1981, that (I) (we) lost saw the deceased alive on 8/15, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jui Chih Hsu		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/15/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jui Chih Hsu		22e. ADDRESS 223 West Main St. Cecil, Md 21921					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/18/81		23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Stockbridge, Mass.	
24. FUNERAL DIRECTOR HICKS HOME FOR FUNERALS, ELKTON, MD.		ADDRESS HICKS HOME FOR FUNERALS, ELKTON, MD.		25a. DATE REC'D. BY REGISTRAR AUG 20 1981		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Edith v. Hodge					2a. DATE OF DEATH MONTH DAY YEAR 8-17-81			2b. HOUR 750a.m.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4-3-21		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Elkton Fashions, Inc.		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13e. STREET ADDRESS 739 Union Church Road			
14. FATHER'S NAME FIRST MIDDLE LAST George - Jones				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie - Wiles					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 246-22-4535		17. INFORMANT ADDRESS Mr. Walter Hodge, Elkton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Oat Cell Carcinoma of the Lung 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Metastases to Brain and Bone									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from July 1979, to August 17, 1981, that (I) (we) lost saw the deceased alive on August 16, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles M. Hensgen MD					DEGREE MD			22c. DATE SIGNED 8/19/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles M. Hensgen MD					22e. ADDRESS North East Rd				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/21/81		23c. NAME OF CEMETERY OR CREMATORY Antioch Baptist Cemetery, Sparza, Md.			23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR Ralph E. Hicks HICKS HOME FOR FUNERALS, ELKTON, MD.									

BP

Edgar

Holmes

1890

1890-1891

1891

1892

March 1892

April

May

June

July

August

September

October

November

December

January

February

1893-1894

1894-1895

1895-1896

1896-1897

1897-1898

1898-1899

1899-1900

1900-1901

1901-1902

1902-1903

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	2	1	3	0	2		
1- FOR STATE REGISTRAR										REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) THOMAS L. HOGE										2a. DATE OF DEATH MONTH DAY YEAR 8-21-81							2b. HOUR 8:10 P.M.	
3. SEX MALE			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 10-7-1908			6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil co. MD.									
10. CITY OR TOWN OF DEATH Elkton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DuPont Co.			12b. KIND OF BUSINESS OR INDUSTRY Civil Eng.									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Delaware										13b. COUNTY N. C.		13c. CITY OR TOWN Newark		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 260 Elkton Rd., Apt C4		
14. FATHER'S NAME FIRST MIDDLE LAST George Hoge					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie G. Gnau													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. --			17. INFORMANT ADDRESS 260 Elkton Rd.; Newark, Del. Gladys T. Hoge (Wife)										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 CARDIAC ARREST, VENTRICULAR FIBRILLATION DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min.																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																		
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from 8-11-1981 to 8-21-1981, that (I) (we) lost saw the deceased alive on 8-21-1981 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.																		
22b. SIGNATURE Ehsanur Rahman										DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EHSANUR RAHMAN										22e. ADDRESS 314 E. MAIN ST, NEWARK, DE 19711								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 8/25/81		23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery					23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington, N.C. Del.						
24. FUNERAL DIRECTOR NAME Wm. J. McCreary										ADDRESS 3924 Concord Pk, Wilm., Del.		25a. DATE REC'D. BY REGISTRAR AUG 27 1981		25b. REGISTRAR'S SIGNATURE				



New York

Elkton

Delaware

E. Walter Wright

No.

Union Hospital

163038991

Cecil Co.

Forrest L. Hunt

Prince Georges County (Virginia)

Stemington 3438482 Silverbrook, Cranston, R.I. Del.

1824 Concord St., Wilmington, Del.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 3 0 3			
1 - FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
I DECEASED NAME (TYPE OR PRINT)				7a. DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR			
GERTRUDE T. LOWEN				AUGUST 14 1981			
3 SEX				7b. HOUR			
Female				12:05pM			
4 RACE				5. DATE OF BIRTH			
White				MONTH DAY YEAR			
July 16, 1892				6 AGE (IN YEARS LAST BIRTHDAY)			
8				7c. CITY OR TOWN			
MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				Cecil			
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				12a. USUAL OCCUPATION			
England				Bookkeeper			
7b. CITIZEN OF WHAT COUNTRY?				12b. KIND OF BUSINESS OR INDUSTRY			
U.S.A.				Engraving Co.			
10 CITY OR TOWN OF DEATH				13a. STREET ADDRESS			
Perry Point				4303 Russell Ave. Apt-2			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				13b. INSIDE CITY LIMITS?			
VA Medical Center				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13c. STREET ADDRESS			
13a. STATE				13c. STREET ADDRESS			
Maryland				4303 Russell Ave. Apt-2			
13b. CITY OR TOWN				13c. STREET ADDRESS			
P.G.				4303 Russell Ave. Apt-2			
13c. CITY OR TOWN				13c. STREET ADDRESS			
Mt. Rainier				4303 Russell Ave. Apt-2			
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST				FIRST MIDDLE LAST			
Albert Edward Toogood				Mary Jane Noble			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			
Yes-Marines				577 09 0093			
(IF YES, GIVE WAR OR DATES)				17 INFORMANT			
W.W.I				Winifred G. Schweinhaut			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) Myocardial Infarction							
4100							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b)							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		70a. AUTOPSY?		70b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <u>November 13, 1980</u> to <u>August 14, 1981</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, if (we) (I) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
<i>M. N. Atay</i>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		8-16-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
M. N. ATAY, M.D.				VAMC, Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		8-18-81		Glenwood Cemetery		Washington D.C.	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
GASCH'S SONS Funeral Home, 4739 Balto Ave, Md				AUG 19 1981 <i>Thomas J. ...</i>			

51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be described for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 3 0 4			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
CHARLES EARL BOWERS				August 26, 1981			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH July 23, 1896		2b. HOUR 8:00pm	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County, MD.	
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance		12b. KIND OF BUSINESS OR INDUSTRY Brick Mfg. Plant	
13a. STATE Maryland				13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS 506 Greenridge Road	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE BOWERS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Zella Kretzer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES-Army				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 6-1-18 / 1-30-19 199-05-6961		17. INFORMANT (See) 838-5342 ADDRESS Mr. Earl C. Bowers 506 Greenridge Road Bel Air, Maryland 21014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral</u> 2041 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic lymphocytic leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 16</u> , 19 <u>81</u> , to <u>Aug. 26</u> , 19 <u>81</u> <del>XXXXXXXXXX</del> above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>M. N. Atay</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8-27-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. N. ATAY, M.D.				22e. ADDRESS VAMC, Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 29, 1981		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Maryland 21014	
24. FUNERAL DIRECTOR NAME Joseph William Foster Foster Funeral Home, Bel Air, Md. 21014				25a. DATE REC'D. BY REGISTRAR SEP 0 1 1981			
				25b. REGISTRAR'S SIGNATURE Francis Jan Kretzer			

BP \_\_\_\_\_

8:00pm

August 26, 1961

NOTES

CHARLES

82

9-4-62, 1962

White

Male

Good County

X

W.A.

W.A.

VA Medical Center

Terry Point

204 Greenidge Road

X

W.A.

W.A.

W.A.

W.A.

W.A.

W.A.

W.A. 204 Greenidge Road  
W.A. 204 Greenidge Road  
W.A. 204 Greenidge Road

100-02-6901

100-02-6901

Chronic lymphocytic leukemia

Bronchopneumonia, bilateral

Aug. 26

Aug. 26

81

Jan. 16

X

XXXXXXXXXXXXXXXXXXXX

8-27-61

X

X

W.A. Terry Point, Md.

W.A. Terry Point, Md.

W.A. Terry Point, Md.

SEP 0 1 1961

W.A. Terry Point, Md.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 1 3 0 5

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Mary E. Lum</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>8 17 81</b> 2b. HOUR <b>2:30a M</b>	
3. SEX <b>female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 25, 1905</b>	
6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>md</b>	7a. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.
10. CITY OR TOWN OF DEATH <b>ELKTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Unkley Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>
13a. STATE <b>md</b>	13b. COUNTY <b>Cecil</b>	13c. CITY OR TOWN <b>Chesapeake City</b>	13d. STREET ADDRESS <b>427 Biddle St.</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Kirkpatrick</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary R.L. Alexander</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-462463</b>	17. INFORMANT ADDRESS <b>Franklin M. Lum Chesapeake City Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4140</b> IMMEDIATE CAUSE (a) <b>ASHED</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Pulmonary TB</b>			
19a. DATE OF OPERATION <b>9 9</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>May</b> , 19 <b>81</b> , to <b>Aug 17</b> , 19 <b>81</b> , that (I) <del>(we)</del> lost saw the deceased alive on <b>13 Aug</b> , 19 <b>81</b> , and that (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> did (did not) view the body after death.			
22b. SIGNATURE <b>Wallace Obenshain MD</b>	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>8-21-81</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Wallace Obenshain</b>		22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (TYPE)	23b. DATE <b>8-20-81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>North East Meth.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>North East Cecil Md.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Paul A. Crouch North East Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 24 1981</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1661.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 2 1 3 0 6	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST George		MIDDLE G.		LAST LUSARDI		2a. DATE OF DEATH MONTH DAY YEAR Aug 29 81		2b. HOUR 10 40 M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 15, 1915		6 AGE (IN YEARS LAST BIRTHDAY) 66		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.					
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance Dept. Univ. of D		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Del.				13b. COUNTY New Castle		13c. CITY OR TOWN Newark		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 97 Wilbur St.	
14. FATHER'S NAME FIRST MIDDLE LAST Dominick Lusardi				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kathryn Hutchison							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT ADDRESS Newark, Del.				17. INFORMANT Victoria A. Lusardi 97 Wilbur St.,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA SPREADING RECTUM</u> 1541 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION 8/3/81		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA, RECTUM				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (the hospital) attended the deceased from 8/1 19 81 to 8/29 19 81, that (I) (we) last saw the deceased alive on 8/29 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
23. SIGNATURE John A. Fischer, MD						DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		23c. DATE SIGNED 8/29/81	
24. PHYSICIAN'S NAME (TYPE OR PRINT) John A. Fischer						24a. ADDRESS 166 W MAIN, ELKTON, MD					
25a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		25b. DATE 9/2/81		25c. NAME OF CEMETERY OR CREMATORY All Saints Cem.		25d. LOCATION CITY OR TOWN COUNTY STATE Newark, New Castle, Delaware					
26. FUNERAL DIRECTOR NAME Robert T. Fisher						ADDRESS Newark, Del		27a. DATE REC'D. BY REGISTRAR SEP 4 1981		27b. REGISTRAR'S SIGNATURE Thane J. G. [Signature]	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_  
DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST Creighton			MIDDLE L.			LAST Lytle Jr.			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 8 17 1981			2b. HOUR M 12:40								
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 20 1960		6. AGE (IN YEARS) LAST BIRTHDAY 20 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 20 1981			2d. HOUR M 12:40								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.											
10. CITY OR TOWN OF DEATH Chesapeake City				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) N. Welch Point- C & D Canal westside of								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student				12b. KIND OF BUSINESS OR INDUSTRY School							
13a. STATE Pa.										13b. COUNTY Delaware		13c. CITY OR TOWN Bloomall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 116 S. Sprout Road							
14. FATHER'S NAME FIRST MIDDLE LAST Creighton Lamar Lytle, Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jane Varken																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No						16b. SOCIAL SECURITY NO. 182-50-1132						17. INFORMANT ADDRESS 116 S. Sprout Rd. Bloomall											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause lost</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR MONTH DAY YEAR 4:30 P.M. 8 17 1981						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject drowned while swimming											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) water						21f. LOCATION STREET CITY OR TOWN COUNTY STATE N. Welch Point westside of C & D Canal Cecil County											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE 						TITLE (SPECIFY) M.D. Assistant						MEDICAL EXAMINER DATE SIGNED 8-21-81											
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.						ADDRESS 111 Penn Street																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE Aug. 24, 1981						23c. NAME OF CEMETERY OR CREMATORY Valley Forge Mem. Garden						23d. LOCATION CITY OR TOWN COUNTY STATE King of Prussia Pa.					
24. FUNERAL DIRECTOR NAME See Funeral Home, PA. 2505 Main St., Elbtown, Md.						25a. FILED BY REGISTRAR AUG 23 1981						25b. REGISTRAR'S SIGNATURE 											

X



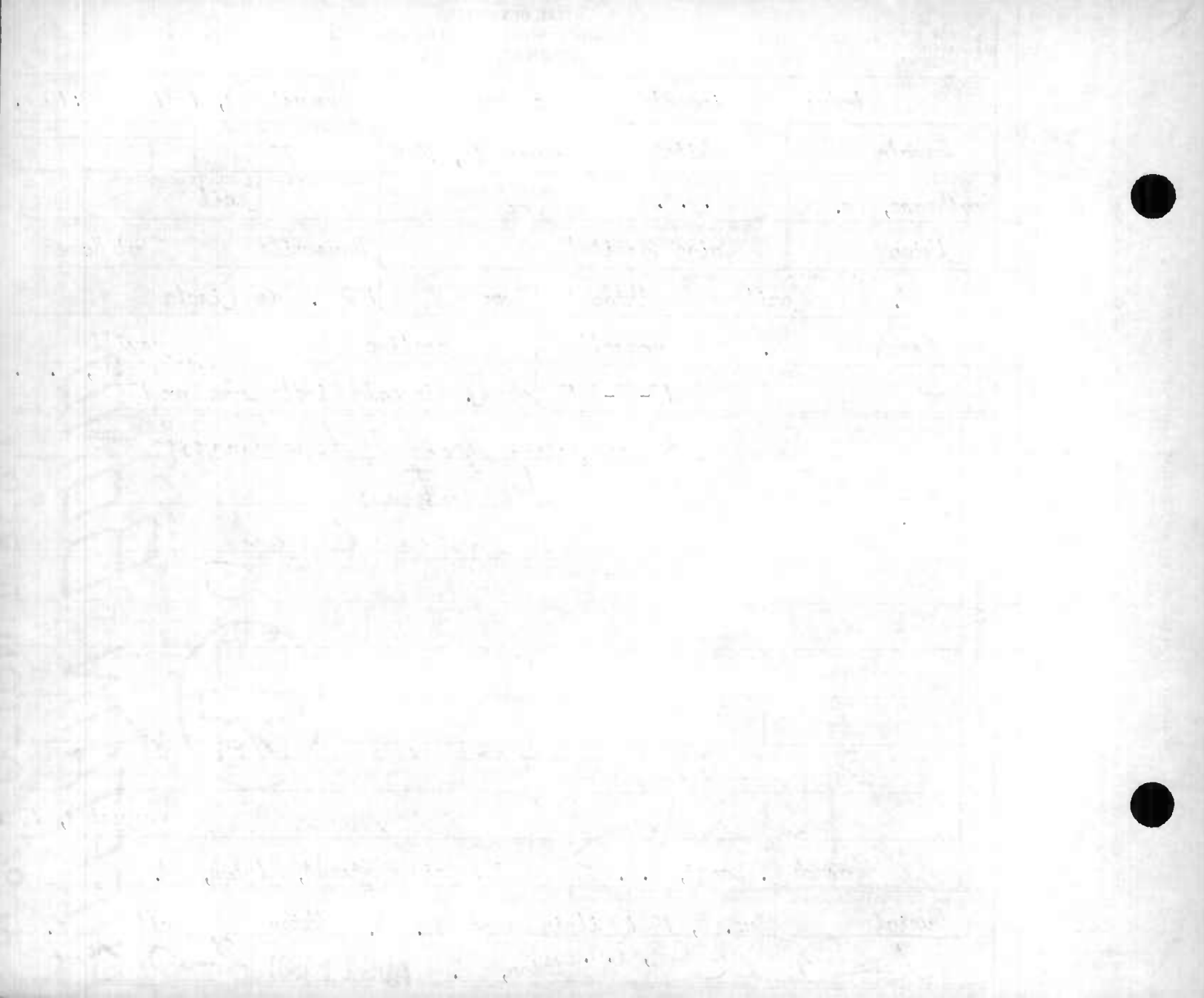
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 2 1 3 0 8	
1 - FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Gladys Ringgold Mc Abee</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>August 4, 1981</i>		2b. HOUR <i>3:10 P.M.</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>January 18, 1906</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <i>75</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Swathmore, Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i> MD.					
10. CITY OR TOWN OF DEATH <i>Elkton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>			
13a. STATE <i>Md.</i> 13b. COUNTY <i>Cecil</i> 13c. CITY OR TOWN <i>Elkton</i> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS <i>102 N. Park Circle</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Frank H. Worrell</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE <i>Caroline Carvill</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>217-60-2817</i>		17. INFORMANT ADDRESS <i>John C. Ringgold Middle Lane Box 175 East Hampton, N. Y.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure &amp; Arrest</i> <i>1830</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cancer Ovary</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) this hospital attended the deceased from <i>4-27-19-81</i> to <i>8/4-19-81</i> , that (b) (we) lost saw the deceased alive on <i>8/4-19-81</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (a) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Joseph G. Lanzzi</i>						DEGREE		22c. DATE SIGNED <i>August 4, 1981</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joseph G. Lanzzi, M.D.</i>						22e. ADDRESS <i>721 Bridge Street, Elkton, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Aug. 8, 1981</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gilpin Manor Mem. Pk.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Elkton Cecil Md.</i>					
24. FUNERAL DIRECTOR NAME <i>Funeral Home</i>						24b. ADDRESS <i>P.A. Elkton, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>AUG 11 1981</i>		25b. REGISTRAR'S SIGNATURE <i>James G. H. H.</i>	

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

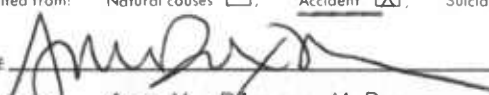

BP

DHMH-17  
(VR A15 AE (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MARIANNE		MIDDLE N.		LAST NORMAN		2a. DATE KNOWN OF DEATH		ESTI- MATED <input checked="" type="checkbox"/>		MONTH 8		DAY 13		YEAR 19 81		2b. HOUR M			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 5 7 43		6. AGE (IN YEARS) (LAST BIRTHDAY) 38 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH 8		DAY 14		YEAR 19 81		2d. HOUR 1:40 a M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina				7b. CITIZEN OF WHAT COUNTRY? US				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.									
10. CITY OR TOWN OF DEATH Elkton				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bartender				12b. KIND OF BUSINESS OR INDUSTRY Hotel					
13a. STATE Maryland				13b. COUNTY Cecil				13c. CITY OR TOWN Elkton				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS Howard Hotel					
14. FATHER'S NAME FIRST MIDDLE LAST Warren C. Thompson Sr.								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna L. McDowell,													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 221-28-6160				17. INFORMANT ADDRESS Mrs. Anna L. Thompson Binns Tract. Newark, Del.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOURS MIN. MONTH DAY YEAR 11:30 AM 8-13- 19 81				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject drowned while swimming.													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) water				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Elk River Chesapeake City Cecil Md.													
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 8-14-81									
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 8-15-81				23c. NAME OF CEMETERY OR CREMATORY Silverbrook Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington, New Castle Del.									
24. FUNERAL DIRECTOR NAME HICKS HOME for FUNERALS, ELKTON, MD.												25a. DATE REC'D. BY REGISTRAR AUG 20 1981				25b. REGISTRAR'S SIGNATURE 					

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*[Faint, illegible text and markings covering the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMM - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 2 1 3 1 0  
CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT)		DATE OF DEATH	
RAYMOND C NOWLAND JR		8 8 81 4:50 AM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)
MALE	CAUCASION	8 02 40	40
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH
MD	U.S.A.		CECIL COUNTY MD.
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY
ELKTON	UNION HOSPITAL OF C.C.	Male	Dressing
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?
MD	CECIL	ELKTON	YES <input type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME	15 MOTHER'S MAIDEN NAME	13e STREET ADDRESS	
ARNOLD	Julia Rhoades	25 BARKSDALE COURT	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS
no	213-36-9066	Carolyn Sue Nowland	25 Barksdale Court
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Brown Melanoma</u>			
1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Advanced Lung Cancer</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
Yogish A. Patel	MD		8/8/81
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		
Yogish A. Patel, Md.D.	179 W. Chestnut Hill Rd., Newark, Del.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	Aug. 11, 1981	Bethel Cemetery	Chesapeake City Cecil Md.
24 FUNERAL DIRECTOR NAME	24b. ADDRESS		24c. DATE REC'D BY REGISTRAR
CECIL FUNERAL HOME	Elkton, Md.		AUG 12 1981

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 3 1 1	
FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR	
Maurice C. OLDHAM				August 23, 1981	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
Male		Black		8/20/1927	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
Maryland		U. S. A.		54 YRS	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Perryville		Perry Point V.A. Center		Cecil County, Maryland MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		12c. STREET ADDRESS	
Waiter		Hotels		Maryland 21215	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Cecil Co.		Perryville	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Maurice Oldham		Gladys Oliver		Yes	
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
WWII		Mrs. Jeanne Saunders		Balto., Md. 21215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
3310		Alzheimer's Disease			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) 2nd to Convulsive Disorder			
		(c) DUE TO, OR AS A CONSEQUENCE OF			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Oct. 23, 1978, to Aug. 23, 1981, and that in my opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
Eugene A. Jaeger M.D.				Aug. 23, 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
Eugene A. Jaeger MD				VA MEDICAL CENTER, PERRY POINT, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		8/27/81		Baltimore National	
23d. LOCATION		23e. CITY OR TOWN		23f. COUNTY	
Baltimore City, Maryland		Baltimore City		Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR	
H. NUTTER., 3035 W. North Ave., Balto., Md. 21216				AUG 26 1981	
25b. REGISTRAR'S SIGNATURE				25c. REGISTRAR'S SIGNATURE	
				AUG 26 1981	

BP \_\_\_\_\_

DHMH-16 50M 1/81  
(VRA 15, 4)

NOTES

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 1 3 1 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MYRTLE M. REYNOLDS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Aug 20 1981</b>			2b. HOUR <b>9:30 PM</b>			
3 SEX <b>Female</b>		4 RACE <b>W</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Mar 1, 1910</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.			
10 CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN FACILITY, GIVE STREET ADDRESS) <b>Union Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S.A.</b>		
13a. STATE <b>Delaware</b>				13b. CITY OR TOWN <b>Middletown</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>Rural</b>	
14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Omer Romack</b>				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Lucy Miller</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>221-14-8521</b>		17. INFORMANT ADDRESS <b>Rupert Reynolds-Middletown, DE</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>congestive heart failure</b> 3949 DUE TO, OR AS A CONSEQUENCE OF (b) <b>myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from <b>8/16</b> , 19 <b>81</b> , to <b>8/20</b> , 19 <b>81</b> , that (2) (we) last saw the deceased alive on <b>8/20</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Kenneth Lewis MD</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/24/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KENNETH LEWIS, MD</b>			22e. ADDRESS <b>12 PENNINGTON ST. MIDDLETOWN, DE</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Aug 24 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Old Rokeby Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Warrenton-Cecil Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Robert C. Hutchison</b>			ADDRESS <b>Middletown, DE</b>			25a. DATE REC'D. BY REGISTRAR <b>AUG 27 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Thomas Jean Vanthorne</b>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

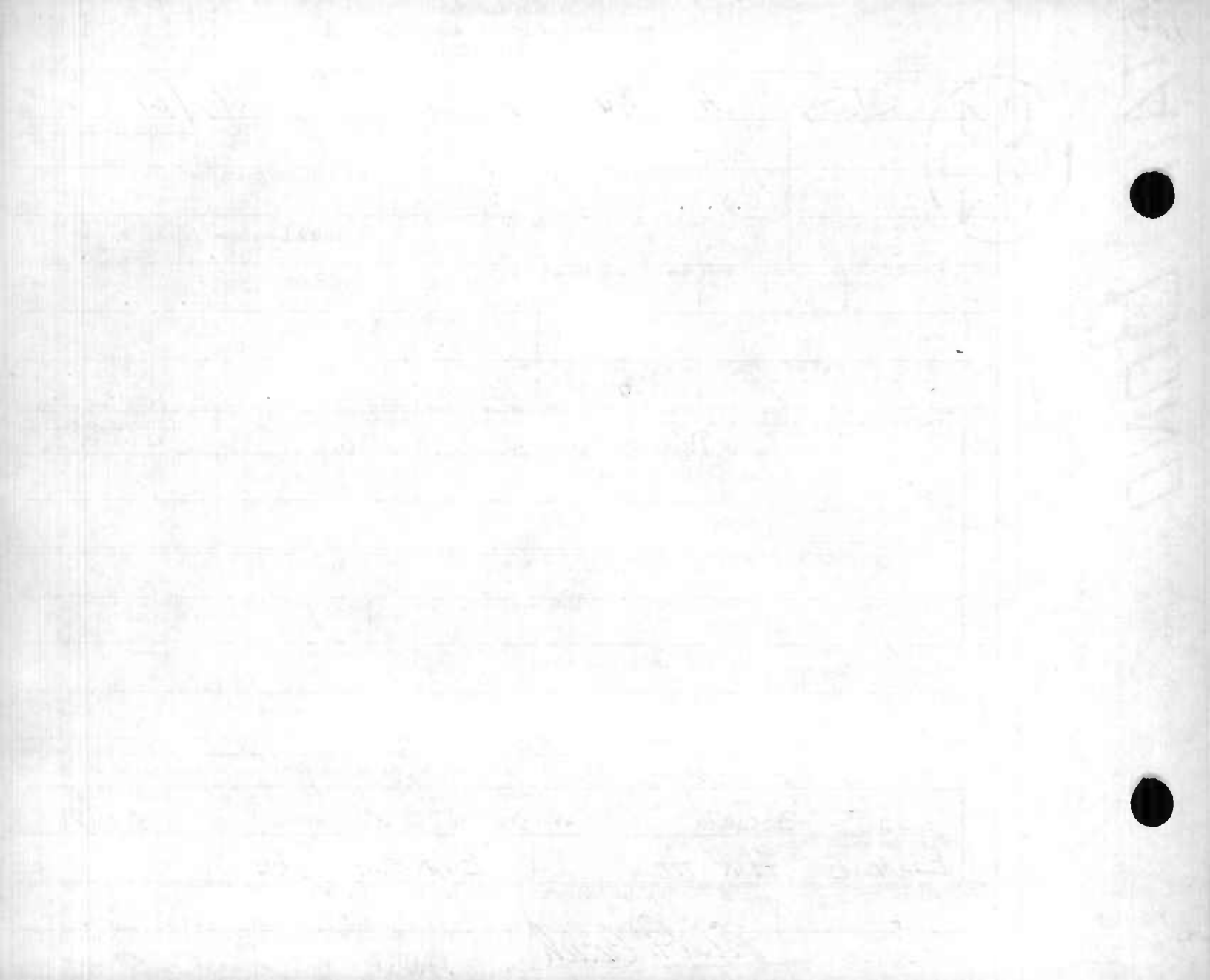
(M)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	2	1	3	1	3	
1- FOR STATE REGISTRAR										CERTIFICATE OF DEATH							
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST Joseph H. Russell Sr.										MONTH DAY YEAR 8/1/81				1100 P. M.			
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male			White			MONTH DAY YEAR March 1, 1917			64 YRS.			MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH								
Maryland			U.S.A.						Cecil County MD.								
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Elkton			Union Hospital							Boiler Opr.			Govt.				
13a. STATE										13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland										Cecil		North East		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		875 Old Phila. Rd.	
14 FATHER'S NAME										15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Alvin Chester Russell										FIRST MIDDLE LAST Etta Mae Smithson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17 INFORMANT											
No			218-01-7328			891 Old Phila. Rd. Joseph Russell Jr. North East, Md.											
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of pancreas</u> <u>1579</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
			HOUR A.M. MONTH DAY YEAR P.M. 19														
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION											
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>7/28</u> 19 <u>81</u> to <u>8/1</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>8/1</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED								
Edgar E. Folk III			M.D.						8/3/81								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
Edgar E. Folk III			Elkton, Md														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION									
Burial			8-5-81		Bay View Cemetery			Bay View Cecil Md.									
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Crouch Funeral Home North East, Md.			AUG 6 1981			James D. North											



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BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 1 3 1 4

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
PERRY		C.		SAUNDERS	August 22, 1981					10:03am	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE	BLACK		NOV. 11, 1905		75		MONTHS DAYS		HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
MD.	U.S.A.				CECIL Co. MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Perry Point		VA Medical Center			Soldier			ARMY			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MD.		Q. A. Co.		Chester town		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R. FO #1			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
HOWARD SAUNDERS				HANNAH ANDERSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
YES		WW #		217-12-4432		MRS. MARGARET WRIGHT CHESTER TOWN					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral</b>											
3334 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Huntington's Chorea</b>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)											
<b>Jaundice due to cancer of ampulla of vater</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from <b>November 10, 1965</b> to <b>August 22, 1981</b> <del>XXXXXX</del> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated											
22b. SIGNATURE <b>Julian Ocejjo M.D.</b> DEGREE <b>MD</b> 22c. DATE SIGNED <b>8-24-81</b>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JULIAN OCEJO, M.D.</b>				22e. ADDRESS <b>VA Medical Center, Perry Point, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (BY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
<b>BURIAL</b>		<b>8-29-81</b>		<b>RICH NECK HALL</b>		<b>CHESTER TOWN MD</b>					
24. FUNERAL DIRECTOR <b>Walley Funeral Home</b> ADDRESS <b>Walley Funeral Home, Chestertown, Md.</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>SEP 3 1981</b> <b>Francis J. [Signature]</b>							

MEDICAL CERTIFICATION



1519



103A, Q 619

Jaundice due to cancer of pancreas or gallbladder

[illegible]

22

THE OLD DOG



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

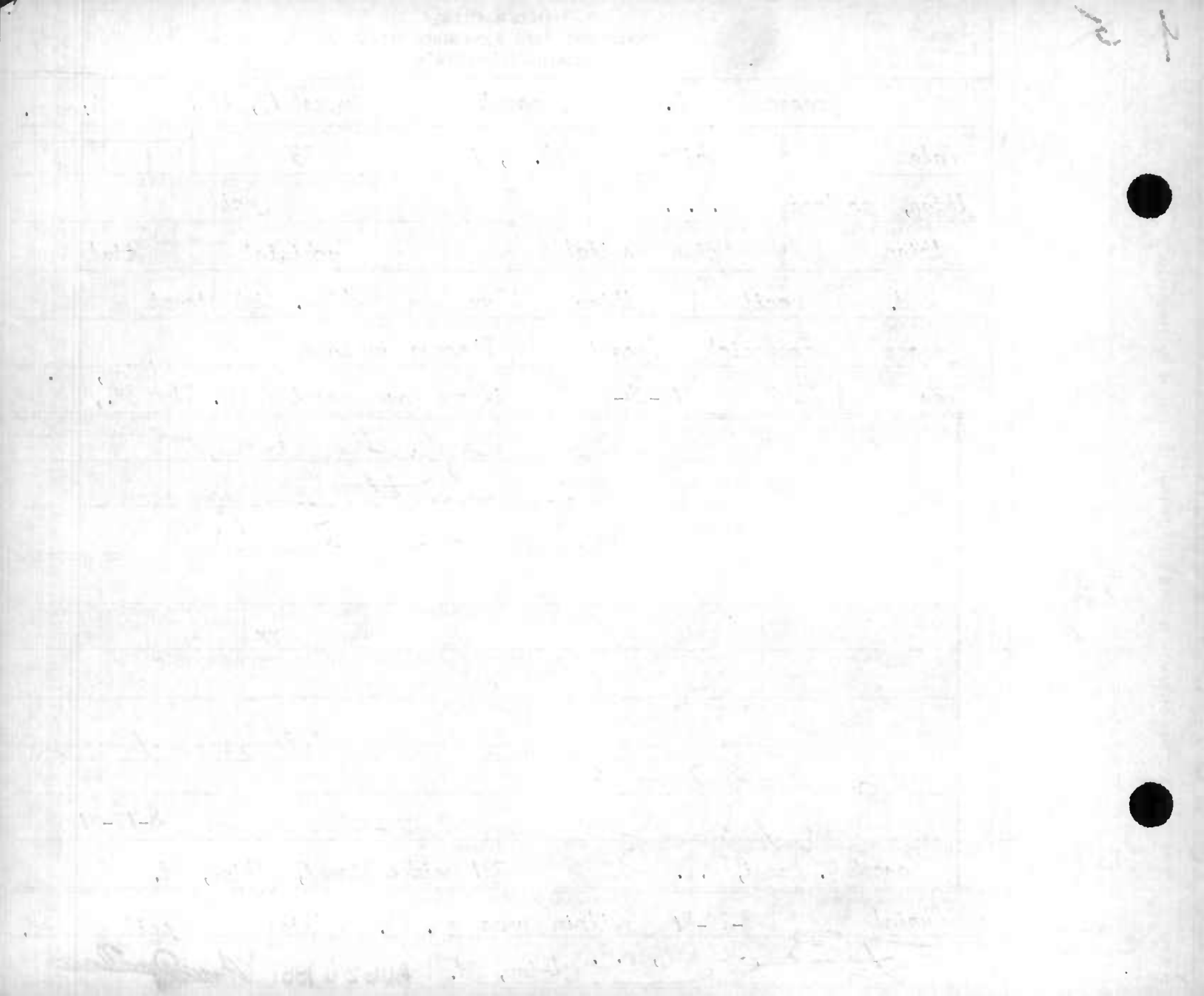
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 3 1 5	
FOR 1 - STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) George K. Sprout			2a. DATE OF DEATH MONTH DAY YEAR August 17, 1981		2b. HOUR 4:00 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 8, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Elkton, Maryland	8b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist	12b. KIND OF BUSINESS OR INDUSTRY Metal	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Cecil 13c. CITY OR TOWN Elkton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 240 W. High Street	
14. FATHER'S NAME FIRST MIDDLE LAST George Frederick Sprout			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa May Logan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2	17. INFORMANT ADDRESS Elkton, Md. Mildred Rose Sprout 240 W. High St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac Arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial Infarction &amp; COPD</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1-1963</u> , 19 <u>81</u> , to <u>8/17</u> , 19 <u>81</u> , that (I) (we) <input checked="" type="checkbox"/> saw the deceased alive on <u>8/17</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)					
22b. SIGNATURE <u>Joseph G. Lanzi, M.D.</u>				22c. DATE SIGNED 8-17-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph G. Lanzi, M.D.				22e. ADDRESS 721 Bridge Street, Elkton, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-20-81	23c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Elkton Cecil Md.
24. FUNERAL DIRECTOR NAME <u>SEE FUNERAL HOME</u> ADDRESS <u>Elkton, Md.</u>				25a. DATE REC'D. BY REGISTRAR AUG 20 1981	

BP



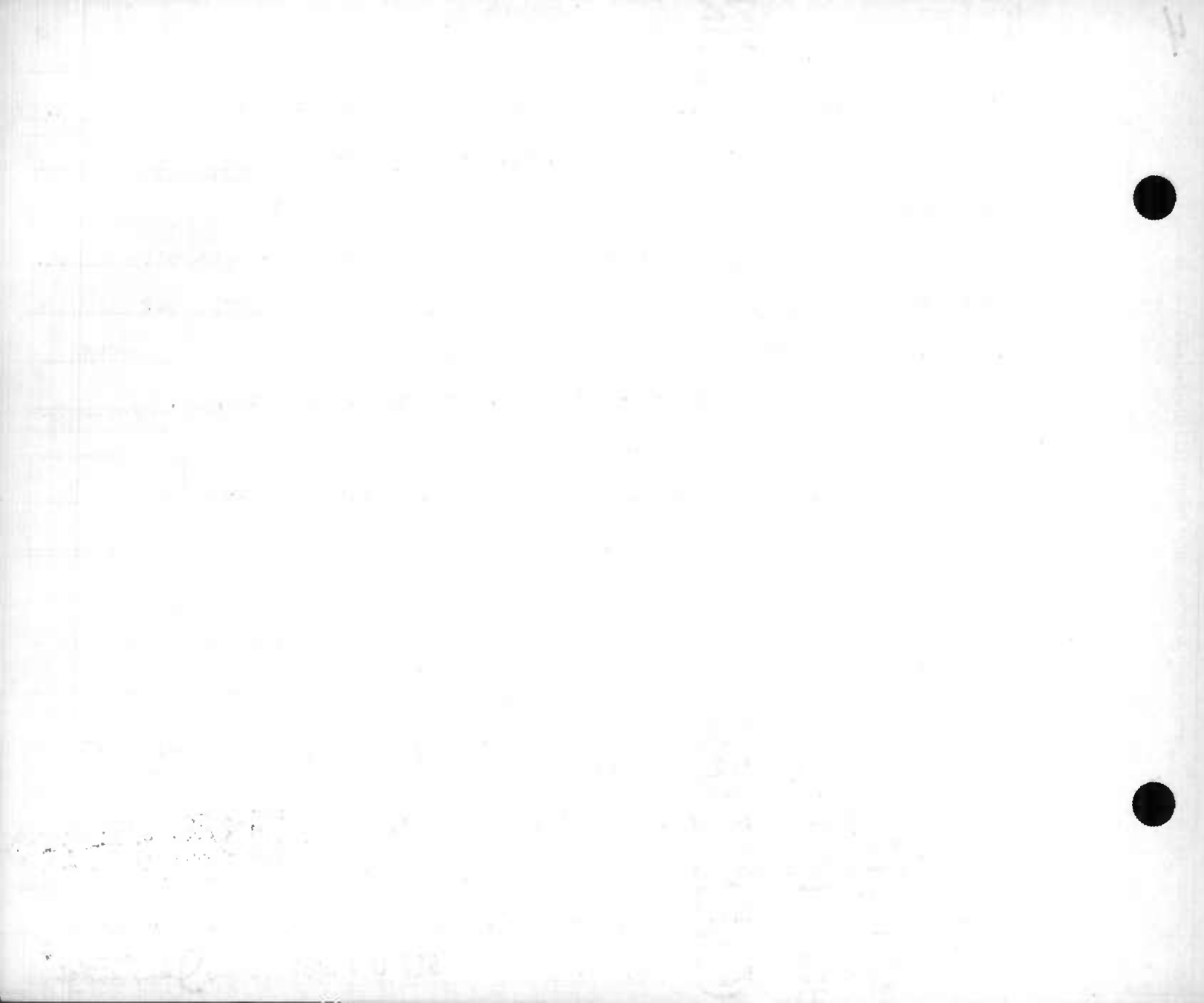
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 1 2 1 3 1 6			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>THERESA M. SPROUT</b>				August 19, 1981			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>NOV. 22, 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.	
10. CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maintenance- University of Del.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Cecil</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>Elkton</b>		13d. STREET ADDRESS <b>3049 Singerly Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>A. Kirk</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Mary Brown</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-07-3045</b>	
17. INFORMANT ADDRESS <b>Mrs. Clarence Dill, Elkton, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CUA</b> <b>2523</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CVI Antecedent Vascular dis</b> (c) <b>Hypertension</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/15</b> , 19 <b>77</b> , to <b>8/17</b> , 19 <b>81</b> , the <b>(1)</b> we last saw the deceased alive on <b>8/19</b> , 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above <b>(I/we)</b> (did not view the body after death)							
22b. SIGNATURE <b>J. V. Hsu</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/22/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. V. Hsu</b>		22e. ADDRESS <b>223 W. Main Street, Elkton, Md. 21921</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/22/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cherry Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cherry Hill, Maryland</b>	
24. FUNERAL DIRECTOR <b>Ralph E. Hicks</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>SEP 01 1981</b>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Lizzie P. Stack</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>8-26-81</i>	
3 SEX <i>Female</i>		2b. HOUR <i>11:50 A.M.</i>	
4 RACE <i>White</i>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN <i>72 YRS.</i>	
5. DATE OF BIRTH MONTH DAY YEAR <i>4-3-09</i>		8. IF UNDER 1 YEAR IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>West Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i> MD.	
10. CITY OR TOWN OF DEATH <i>ELKTON</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Laurelwood Nursing Home</i>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Seamstress</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Sewing</i>	
13a. STATE <i>md.</i>		13b. COUNTY <i>Cecil</i>	
13c. CITY OR TOWN <i>North East</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <i>3 Mill Lane</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Henry Okey Carte</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ada Collins</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>2 33-22-7756A</i>	
17. INFORMANT ADDRESS <i>Newark Del 1836 Ott Chapel</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Renal Failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Atherosclerosis</i> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>8/26</i> 19 <i>81</i> , to <i>8/26</i> 19 <i>81</i> , that (I) (we) lost saw the deceased alive on <i>8/26</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Joseph Lanzi</i>		22c. DATE SIGNED <i>8-26-81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joseph Lanzi</i>		22e. ADDRESS <i>721 Bridge St. Elkton, Md. 21921</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Aug. 29, 1981</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>North East Meth.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>North East Cecil Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Robert J. Carter</i>		25a. DATE REC'D. BY REGISTRAR <i>AUG 27 1981</i>	
ADDRESS <i>North East, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Van Natta</i>	

BP

1875  
The following is a list of the  
names of the persons who  
were present at the  
meeting of the  
Board of Directors  
of the  
Company, held on  
the 1st day of  
January, 1875.

(1875)

Wm. H. Smith  
J. H. Jones  
J. H. Jones

Wm. H. Smith  
J. H. Jones  
J. H. Jones

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 2 1 3 1 8			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
JAMES		B.		STATEN				August 4, 1981				2:00 pm	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		Black		Apr. 8, 1913		68 YRS		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						MD.	
N.C.		USA				Cecil Co.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Perry Point		VA Medical Center				Disabled Veteran							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
District of Columbia		Washington		YES <input type="checkbox"/> NO <input type="checkbox"/>				1031 5th Street, N.E.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST			
John Staten		Peninia Baker											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
yes		240-01-0214		Mrs. Edna Staten-wife-1031 5th Street									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY													
IMMEDIATE CAUSE (a) Cardiac arrest													
4140 DUE TO, OR AS A CONSEQUENCE OF													
(b) Arteriosclerotic heart disease													
DUE TO, OR AS A CONSEQUENCE OF													
(c) Respiratory failure 2nd to above													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)													
Lung tumor													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION									
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				STREET				CITY OR TOWN COUNTY STATE					
22a. I certify that (x) (this hospital) attended the deceased from January 20, 1981, to August 4, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated													
22b. SIGNATURE													
Joaquin B. Garcia M.D.													
22c. DATE SIGNED													
8-5-81													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)													
J. B. GARCIA, M.D.													
22e. ADDRESS													
VA Medical Center, Perry Point, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
Burial		Aug. 8, 1981		Old Mill Cemetery		CITY OR TOWN		COUNTY STATE					
						Bestan, N.C.							
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
NAME		AUG 10 1981		Name Jan. Nathan									
Stewart Funeral Home, Washington, DC													

BP

2:00 PM

August 4, 1981

STATE

MEMO

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100-1-0114

100-1-0114

100-1-0114

VA Medical Center

VA Medical Center

VA Medical Center

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
8 1 2 1 3 1 9									
1- FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST <i>Agnes A. Stetson</i>					MONTH DAY YEAR <i>8/4/81</i>				
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Female		White		MONTH DAY YEAR <i>MAY 27, 1907</i>		74		<i>650P</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA				Cecil MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Elkton		Union Hospital				Registered Nurse			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Cecil		Elkton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2934 Singerly Road	
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST <i>Andrew - Angle</i>					FIRST MIDDLE LAST <i>Emma - Hall</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
No		221-16-8110		Mr. Alan E. Stetson, Elkton, Md.					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> 4380 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <i>8/4/81</i> to <i>8/4/81</i> , that (2) (we) lost <i>8/4/81</i> saw the deceased alive on <i>8/4/81</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death?									
22b. SIGNATURE					DEGREE		22c. DATE SIGNED		
<i>Ernesto A. Blang M.D.</i>					M.D. - ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		<i>8/4/81</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
<i>Ernesto A. Blang</i>					<i>Elkton, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. STATE	
Burial		<i>8/7/81</i>		Cherry Hill Meth. Cemetery, Cherry Hill, Md.		CITY OR TOWN COUNTY			
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
<i>Ralph E. Hicks</i>					<i>AUG 11 1981</i>		<i>James E. Martin</i>		
HICKS HOME FOR FUNERALS, ELKTON, MD.									

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 2 1 3 2 0			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) Annie B. Tinsley				2a DATE OF DEATH MONTH DAY YEAR Aug. 18, 1981		2b HOUR 1:35 PM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR July 31, 1891		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10 CITY OR TOWN OF DEATH Rising Sun		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Manor Nursing Home, Inc.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher		12b KIND OF BUSINESS OR INDUSTRY Education	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Delaware				13b COUNTY New Castle		13c CITY OR TOWN Newark	
14 FATHER'S NAME FIRST MIDDLE LAST Basil M. Phifer				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Belle Cross			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 239-74-0744		17 INFORMANT ADDRESS Newark, Del. 19711 Charles H. Tinsley, 104 Tanglewood Lane			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>AS.C.V.D.</u> (c) <u>5 yrs.</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>1-18</u> 19 <u>81</u> to <u>8-18</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>8-18</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Neil Taylor MD				DEGREE MD		22c DATE SIGNED 8/18/81	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Neil Taylor Jr MD				22e ADDRESS Rising Sun, Maryland			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 8/21/81		23c NAME OF CEMETERY OR CREMATORY Yarborough's Chapel Cemetery, Cross Anchor, S.C.		23d LOCATION CITY OR TOWN COUNTY STATE	
24 FUNERAL DIRECTOR NAME Ralph E. Hicks				25a DATE REC'D. BY REGISTRAR AUG 24 1981			
HICKS HOME for FUNERALS, ELKTON, MJ.				25b REGISTRAR'S SIGNATURE James J. [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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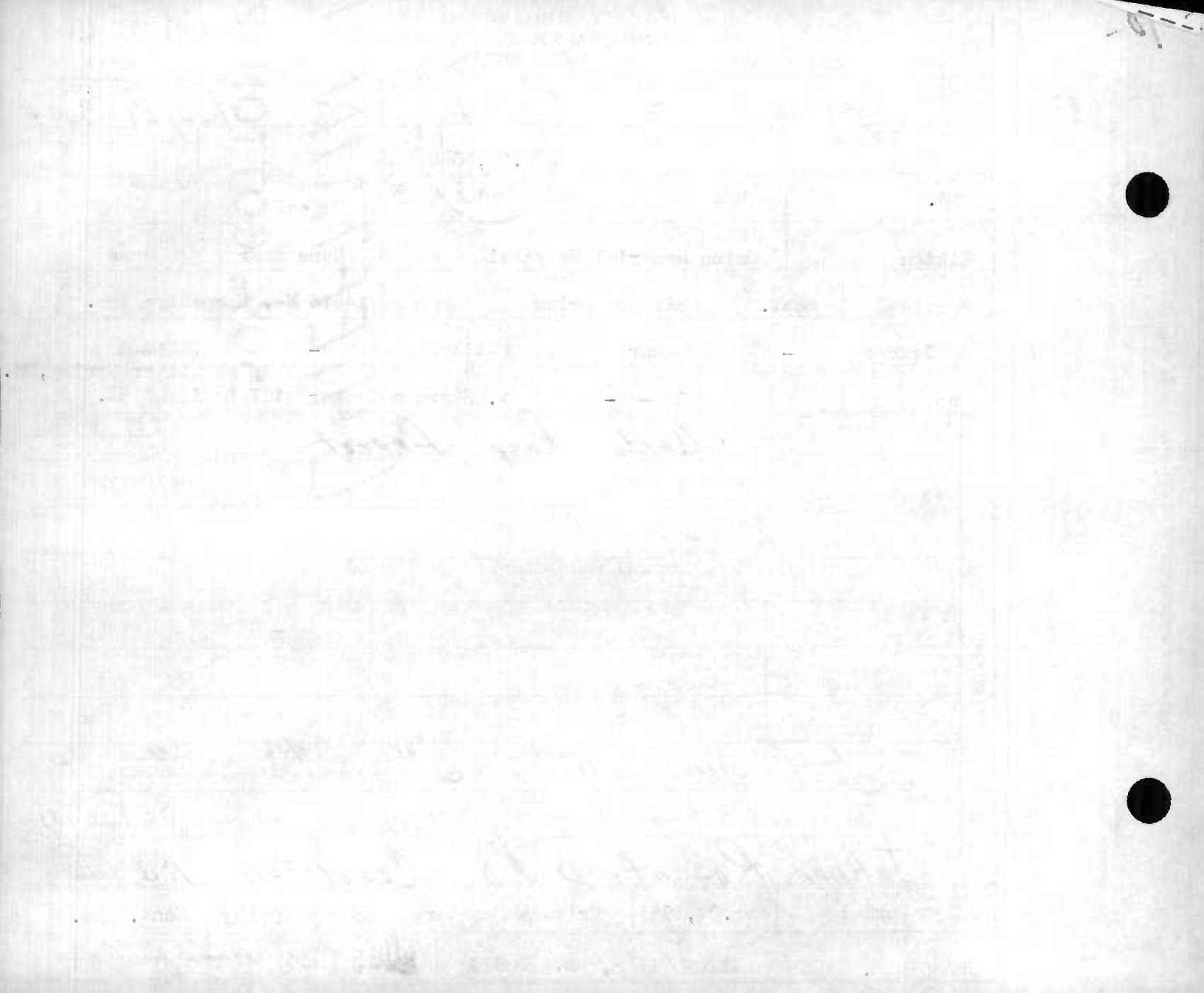


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 1 2 1 3 2 1	
CATHERINE		ELsie		TUCKER	
1. DECEASED NAME (TYPE OR PRINT) <i>Catherine R. Tucker</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>8/26/81</i>		2b. HOUR <i>309 A</i>	
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 24, 1888</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>92</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) <i>Ma.</i>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.	
10. CITY OR TOWN OF DEATH <b>Elkton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Mont.</b>	13c. CITY OR TOWN <b>Silver Spring</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George - Tucker</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Matilda - JOHNSON</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>220-46-0726</b>		17. INFORMANT ADDRESS <b>W. Sherman Tucker 127 Bonifant Rd. Silver Spring, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <i>4275</i> IMMEDIATE CAUSE (a) <b>CARDIO Resp Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>8/25</i> 19 <i>81</i> , to <i>8/26</i> 19 <i>81</i> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <i>8/26</i> 19 <i>81</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did (did not) view the body after death.					
22b. SIGNATURE <i>JoAnn Rosenfeld, MD</i>				22c. DATE SIGNED <i>8/26/81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JoAnn Rosenfeld M.D.</i>				22e. ADDRESS <i>Cecil ton Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Aug. 28, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Friends Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sandy Spring Mont. Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 31 1981</b>			
24. FUNERAL DIRECTOR NAME <b>FRANCIS H. BARBER</b>		ADDRESS <b>LAYTONSVILLE, MD. 20879</b>		25b. REGISTRAR'S SIGNATURE <i>Francis H. Barber</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

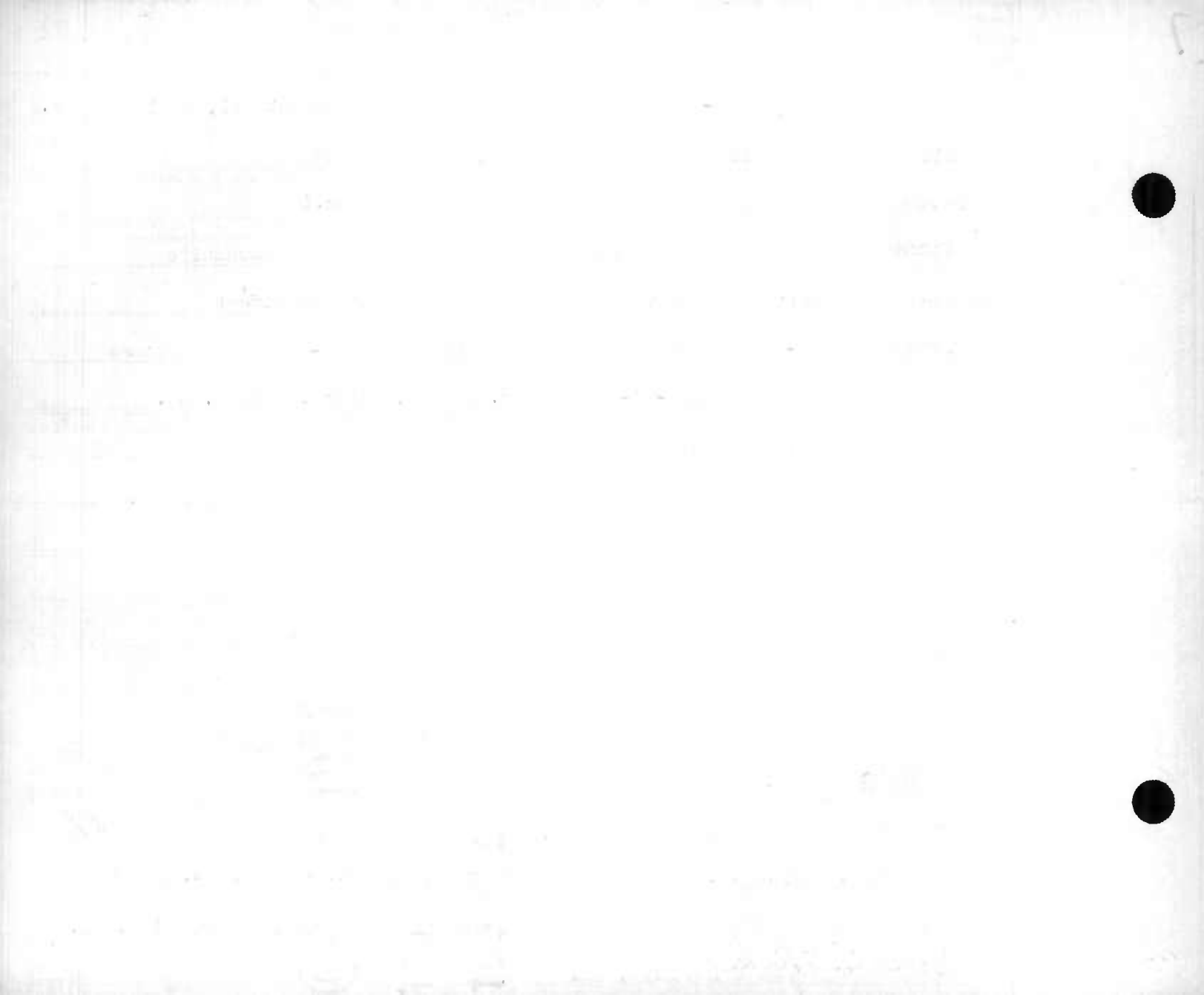
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 2 1 3 2 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELEANOR - ULRICH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 17, 1981</b>		2b. HOUR a.m. p.m. <b>a.m.</b>		
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>FEBRUARY 8, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kansas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b>		10. CITY OR TOWN OF DEATH <b>Elkton</b>					
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Cecil</b>	13c. CITY OR TOWN <b>Elkton</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>520 Bow Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John - Schamne</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna - Hoffman</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-72-1679</b>		17. INFORMANT ADDRESS <b>Mr. John J. Ulrich, Elkton, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>VENTRICULAR FIBILLATION</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (1) <del>the</del> hospital attended the deceased from <b>1965</b> to <b>present</b> 19 <b>81</b> , that (1) <del>the</del> last saw the deceased alive on <b>JUNE</b> 19 <b>81</b> , and that in (my) <del>the</del> opinion death occurred on the date and hour and from the causes stated above. (If the doctor did not view the body after death.)							
22a. SIGNATURE <b>Robert L. Gray</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/19/81</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert L. Gray, M.D.</b>		22d. ADDRESS <b>719 Bridge Street, Elkton, Md. 21921</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/20/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Immaculate Conception Cemetery, Cherry Hill, Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Ralph E. Hicks</b>		ADDRESS <b>HICKS HOME FOR FUNERALS, ELKTON, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 20 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Rose Ann Norton</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 2 1 3 2 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARGARET J. WALKER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 28, 1981</b>		2b. HOUR <b>a.m.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 7, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.	
10. CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>Elkton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>August - Damanski</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna - Rush</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>083-16-8909</b>		17. INFORMANT ADDRESS <b>Raymond B. Fields, Syracuse, N.Y. 13203</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>QSAH</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3</b> 19 <b>81</b> , to <b>8</b> 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>8-28</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)							
22b. SIGNATURE <b>Joseph G. Lanzi</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/31/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph G. Lanzi, M.D.</b>		22e. ADDRESS <b>721 Bridge Street, Elkton, Md. 21921</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/31/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gilpin Manor Memorial Park, Elkton, Maryland</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Joseph E. Hicks</b> ADDRESS <b>HICKS HOME FOR FUNERALS, ELKTON, MD.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 14 1981</b>			
				25b. REGISTRAR'S SIGNATURE <b>James J. Harrison</b>			

BP

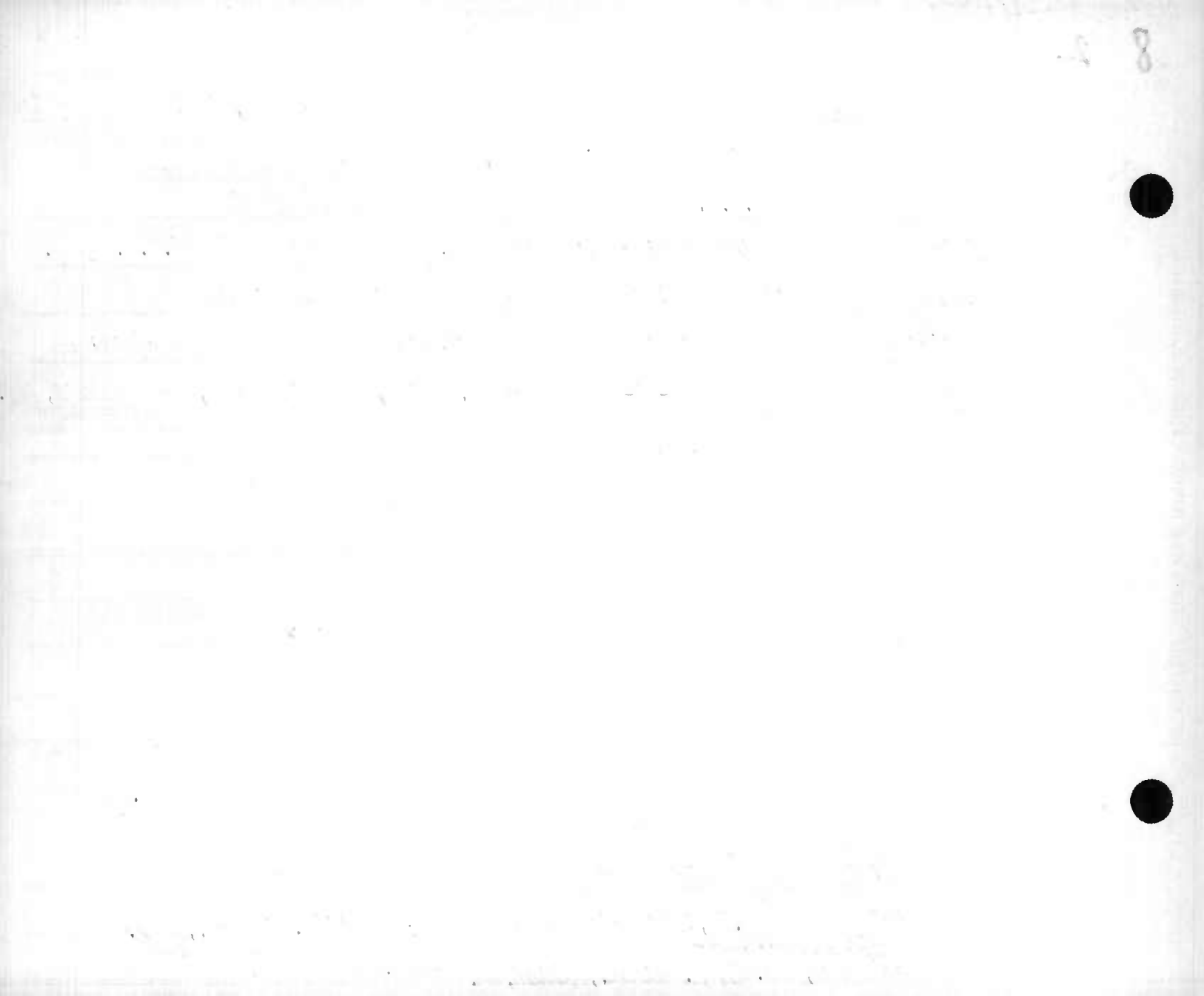


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 2 1 3 2 4			
1- FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY A WHITEMAN				2a DATE OF DEATH MONTH DAY YEAR August 22, 1981		2b HOUR 8:55 AM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR October 3, 1920		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 60 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vermont		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.	
10 CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil County		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder		12b KIND OF BUSINESS OR INDUSTRY R.M.R. Corp.	
13a STATE Maryland				13b COUNTY Cecil		13c CITY OR TOWN Elkton	
14 FATHER'S NAME FIRST MIDDLE LAST William Biskirk				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine McJettigan			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO 204-07-1004		17 INFORMANT ADDRESS Mary E. Smith, 775 Frist Road, Port Deposit, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of lung</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SEVERAL YEARS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>8/21</u> 19 <u>81</u> to <u>8/22</u> 19 <u>81</u> , that (I) (we) most saw the deceased alive on <u>8/22</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Vincent T Brandeis				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 8/22/81	
22d PHYSICIAN'S NAME (TYPE OR PRINT) VINCENT T BRANDIS				22e ADDRESS UNION HOSPITAL - ELKTON			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Aug. 25, 1981		23c NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Phila. Dela. Pa.	
24 FUNERAL DIRECTOR NAME See Funeral Home				ADDRESS PA. 259 E. Main St., Elkton, Md.		25a DATE REC'D. BY REGISTRAR AUG 26 1981	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	2	1	3	2	5
1. FOR STATE REGISTRAR										REG. NO.						
1 DECEASED NAME (TYPE OR PRINT) <b>CHARLES SAMUEL WILHELM</b>										2a. DATE OF DEATH <b>AUGUST 12 1981</b>			2b. HOUR <b>3:00p<sub>M</sub></b>			
3. SEX <b>Male</b>			4 RACE <b>White</b>			5. DATE OF BIRTH <b>May 09 1911</b>			6 AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS HOURS MIN.		
7a BIRTHPLACE (S. MAJOR FOREIGN) <b>Male Sykesville Md.</b>			7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil County MD.</b>							
10 CITY OR TOWN OF DEATH <b>Perry Point</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center</b>							12a USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Barber</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Barbering</b>			
13a STATE <b>Maryland</b>			13b COUNTY <b>Dorchester</b>			13c CITY OR TOWN <b>Cambridge</b>			13d. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>			13e. STREET ADDRESS <b>205 Brohawn Avenue</b>				
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Ernest</b> LAST <b>Wilhelm</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>Archie</b> LAST <b>Ridgley</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>WW II 220 16 8066</b>			17. INFORMANT ADDRESS <b>Elsie Deane Mooney Cambridge, Maryland</b>										
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe Anemia due to</b> <b>5850</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>persistent uremia</b> (c) <b>chronic renal failure</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES <input type="checkbox"/> NO <input type="checkbox"/></b>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (x) (this hospital) attended the deceased from <b>Feb. 10</b> 19 <b>81</b> to <b>Aug. 12</b> 19 <b>81</b> <del>XXXXXX</del> <del>XXXXXX</del> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated																
22b. SIGNATURE <b>Julian Ocejio M.D.</b>										DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JULIAN OCEJO, M.D.</b>										22e. ADDRESS <b>VAMC, Perry Point, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8-14-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veterans Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hurlock Dorchester Md.</b>								
24. FUNERAL DIRECTOR NAME <b>CURRAN FUNERAL HOME</b>										ADDRESS <b>308 High St., Cambridge, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 17 1981</b>		25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>		

MEDICAL CERTIFICATION

DAVIDS BARNETT WILLIAMS AMST 12 1981 2:00p

Berry Point VA Medical Center

200 16 0066

Severe incident due to

perforated appendix

chronic renal failure

Ref. 10 81 Aug. 12 81 x  
XX

JULIAN OCELO, M.D. VAMC, Berry Point, Md.

UTMAN KURTAL HOME 308 High St., Cambridge, Md.

be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M / 81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 1 3 2 6

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
PAULINE H. WOOD		8-27-81		4:20 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
Female	W	3 31 27	54 yrs.	Cecil	
7a. BIRTHPLACE (STATE OF BIRTH)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH	10. BALTIMORE CITY OR COUNTY OF DEATH	
Delaware	H.S.A.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Cecil	Cecil	
11. CITY OR TOWN OF DEATH	12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF HOME, GIVE STREET ADDRESS)	13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	13b. KIND OF BUSINESS OR INDUSTRY	14. FATHER'S NAME	
Elkton	Union Hospital	Housewife		Albert	
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	16. COUNTY	17. INSIDE CITY LIMITS?	18. STREET ADDRESS	19. MOTHER'S M maiden name	
Maryland	Cecil	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	48 Willow Court	Shaban	
20. FATHER'S NAME	21. MOTHER'S M maiden name	22. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	23. SOCIAL SECURITY NO.	24. INFORMANT	
Albert	Shaban	No	221-163753	Lee R. Wood - Elkton, Md.	
25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Oat Cell Ca of Lung & Mets					
1629					
DUE TO, OR AS A CONSEQUENCE OF					
(b) Debilitated Gen. Condition					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-15-81 19 to 8-27-81 19, that (I) (we) lost saw the deceased alive on 8-27-81 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Jayantilal K. Patel		MD -		8/29/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR	
JAYANTILAL K. PATEL MD		123 Singlerly Ave - ELKTON MD 21921		SEP 2 1981	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Aug 31, 1981		Towson Cemetery Towson, Md.	
24. FUNERAL DIRECTOR		24a. DATE REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
James C. Peterson		SEP 2 1981		James C. Peterson	



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